SMG Chestnut Street, SMG Elm Street, SMG Mancos Valley, Southwest Walk-In Care, Southwest School-Based Health Center, SMG Market Street, SMG Orthopedics, SMG Pulmonary and Sleep Medicine, SMG General Surgery, SMG Podiatry

NOTICE TO OUR PATIENTS

Thank you for choosing us as your healthcare provider. We look forward to providing an office environment and provider relationship that meets you and/or your family's medical needs.

Items to bring to your first appointment:

1. Driver's license or other photo identification.
2. All insurance cards.
3. Co-pays or payment in full at the time of your visit if you are not covered by insurance.
4. Actual bottles of all medications (prescribed and over the counter) that you are currently taking.

No-Show Policy

Our policy is to call patients the business day prior to their scheduled appointment to remind them of the appointment date and time. We perform these calls as a courtesy to our patients and to allow us the opportunity to reschedule the time slot should the appointment not be necessary. A phone call from you to cancel your appointment will allow us to schedule another patient that needs to be seen. Recognizing that everyone's time is valuable and that appointment time is limited, we ask that you provide **24 hours notice** if you are unable to keep your appointment. This will allow us to call one of our patients on a waiting list to fill the available slot on the schedule.

To improve care for our patients, we will track all "No-Show" visits. Each patient will be allowed to miss two scheduled appointments within a **one year period** without penalty. Once a third appointment is missed, the patient will be at risk of being discharged from the practice or the Southwest Medical Group. To prevent this from happening, patients shall receive a letter each time they no-show for an appointment reminding them of our no-show policy.

For the purposes of this policy, a no-show appointment is defined as follows:

1. An appointment which is missed by the patient without any advance notice.
2. An appointment that is cancelled less than 24 hours prior to the scheduled appointment time.
3. An appointment in which the patient arrives 10 minutes or more beyond the scheduled appointment time.

Failure to show for the initial "new patient" appointment may eliminate your opportunity to establish care as a new patient.

Rx Refill Policy

Our policy is to refill patient prescriptions within 72 (business) hours of receiving the request. Please do not wait until you are completely out of medication or you will likely do without until the refill can be processed.

Patient Name: _____ Date of Birth:_____

Signed (signature required):_____ Date/Time:_____

Patient, Parent or Legal Guardian:_____ Date/Time:_____

SOUTHWEST MEDICAL GROUP

SMG Chestnut Street, SMG Elm Street, SMG Mancos Valley, Southwest Walk-In Care, Southwest School-Based Health Center, SMG Market Street, SMG Orthopedics, SMG Pulmonary and Sleep Medicine, SMG General Surgery, SMG Podiatry

NEW PATIENT / HISTORY INFORMATION - ADULT

Date:_____

Patient Name: _____
First Name Middle Name Last Name

Date of Birth:_____ Age:_____ Gender: Male Female

Street Address:_____ City/State/Zip:_____

Mailing Address (if different):_____ City/State/Zip:_____

Best Contact Number:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____

Would you like to sign up for our Southwest Medical Group patient portal? ☐ No ☐ Yes

Social Security #_____ - _____ - _____ Primary Care Physician:_____

Language:_____ Race: [American Indian or Alaska Native/ Native American /

African American / Asian / Chinese / Filipino / Japanese / White / Hispanic / Native Hawaiian / Other]

Marital Status: [Single Married Separated Divorced Widowed] Number of Children_____

Occupation:_____ Retired? Y / N

Patient's Employer:_____

Business Address:_____ Phone: _____

Name of Primary Insurance:_____ Name of Primary Insurance Holder:_____

Member ID#:_____ Group #:_____

Name of Secondary Insurance:_____

Member ID#:_____ Group#:_____

Patient's Relationship to Insurance Holder:_____

In case of Emergency, who should be notified? Name:_____

Relationship to Patient:_____ Contact Phone Number:_____

Patient Name: _____ Date of Birth: _____
First Name Middle Name Last Name

Please list providers whom you have received care from in the past:

Primary Doctors: _____

Other Doctors: _____

Current Medications:

(*include all over-the-counter drugs or products such as, aspirin, nose sprays, herbs, vitamins, etc.)*

Name of Drug	Dose	Times Per Day

Preferred Pharmacy:_____ **Address (City):**_____

Allergies: *(include medications, pollens, foods, and animals)*

Drug / Type	Reaction

Past Medical History (*Please circle Yes or No to indicate if you have ever had the following)*

Disease or Condition	Y	N	Duration
Alcoholism	Yes	No	
Anemia / Blood Disorders	Yes	No	
Arthritis / Gout	Yes	No	
Asthma or other Respiratory Problems	Yes	No	
Cancer **Type:**	Yes	No	
Diabetes	Yes	No	
Drug Addictions **Type:**	Yes	No	
Eye Disease	Yes	No	
Frequent or Serious Infections	Yes	No	
Heart Disease / Attack	Yes	No	
High Blood Pressure	Yes	No	
High Cholesterol	Yes	No	
Hormone Problems	Yes	No	
Kidney Disease / Stones	Yes	No	
Liver Disease / Hepatitis **Type:**	Yes	No	
Lung Disease / COPD	Yes	No	
Mental Health Problems or Depression	Yes	No	
Muscle Weakness	Yes	No	
Nerve Disorders / Migraines / Seizures	Yes	No	
Reflux / Heartburn / GERD/ Ulcers	Yes	No	
Rheumatic Fever	Yes	No	
Serious Injuries or Fractures	Yes	No	
Skin Disease	Yes	No	
STD / Genital Problems	Yes	No	
Stroke	Yes	No	
Thyroid Problems	Yes	No	
Tuberculosis	Yes	No	
Urinary Disorders/Prostate problems/ Incontinence	Yes	No	

Have you ever had a history of blood clots in legs or lungs (pulmonary embolus)? ☐ No ☐ Yes

Other Medical Problems Not Mentioned Above

Disease or Condition	Duration / Year

Past Surgical History: *(include ALL surgeries and left or right side if applicable)*

If you have ever had surgery, please list the types and approximate date(s):

Year	Operation	Anesthesia	Any Complications with Surgery or Anesthesia?

Have you ever received a blood transfusion? ☐ No ☐ Yes If yes, what year_____

Have you ever been hospitalized for any illness? ☐ No ☐ Yes

If yes, for what illness and year of hospitalization(s)?_____

Please list any street drugs currently used: ☐ Marijuana ☐ Other(s): _____

Prior Tests / Exams History

Prior Tests / Exams	Y	N	Year	Normal / Abnormal
Bone Density (after 65)	Yes	No		
Colonoscopy (after 50)	Yes	No		
Lipids/Cholesterol (after 45)	Yes	No		
Mammogram (after 40)	Yes	No		
Pap Smear/Pelvic	Yes	No		
Stress Test	Yes	No		
Thyroid Function Test	Yes	No		
HIV Test	Yes	No		
Last Dental Exam	Yes	No		
Last Vision Exam	Yes	No		

Diabetic History

Fasting Blood Sugar: _____ Last A1C Date:_____ Percentage: _____

Immunization History **(please list date of last immunization or test)**

Chicken Pox Vaccine Date:_____

Flu Vaccine Date:_____

Hepatitis Vaccine Date:_____

Pneumonia Vaccine Date:_____

Polio Vaccine Date:_____

Rubella or MMR Vaccine Date:_____

Shingles Vaccine Date:_____

Tetanus Vaccine Date:_____

TB Skin Test Date:_____

HPV Vaccine Date(s):_____

(ages 9-26; ideally ages 9-12 both females and males)

Family History

Are you adopted? ☐ No ☐ Yes

Relation	Living?	Age	Age at Death (if deceased)	Cause of Death
Father				
Mother				
# Brother(s): _____	# living: ___			
# Sister(s): _____	# living:___			

Please indicate who (if any) of <u>YOUR IMMEDIATE BLOOD RELATIVES</u> have had any of the following:
[Please list which relative(s) and the type of disease or condition if applicable, <u>(ex.- grandmother, mother's side, lung cancer)</u>]

Disease or Condition	Relationship to You	Type *(if applicable)**
Alcohol or Drug Dependency		*
Arthritis / Gout		*
Asthma / Hay Fever		
Breast Cancer		
Colon Cancer		
Diabetes		*
Heart Disease / Attack		
High Blood Pressure		
High Cholesterol		
Kidney Disease		
Lung Disease / COPD		
Mental Health Problems or Depression		*
Migraines / Seizures		
Multiple Sclerosis		
Obesity / Weight Disorder		*
Osteoporosis		
Other Cancer		*
Ovarian Cancer		
Parkinson's		
Stroke		
Thyroid Disorders		
Tuberculosis		
Uterine Cancer		

For Females:

Pregnancies

Year	Delivery Type	Any Complications?
	☐Vaginal ☐ C-Section	
	☐Vaginal ☐ C-Section	
	☐Vaginal ☐ C-Section	
	☐Vaginal ☐ C-Section	

Abortions: ☐ No ☐ Yes #_____ Miscarriages: ☐ No ☐ Yes #_____

Last menstrual period:_____ Birth Control : ☐ No ☐ Yes Type: _____

Menopause: ☐ No ☐ Yes Age:_____ Hysterectomy: ☐ No ☐ Yes

Social History

Born in: _____ Raised in: _____ Living in:_____ For how long?:_____

Religion: _____

Highest Education Level Achieved: ☐ Elementary ☐ Jr. High ☐ High School ☐ College ☐ Post-Graduate

Do you feel safe in your home? ☐ No ☐ Yes Have you ever been abused (physical/sexual)? ☐ No ☐ Yes

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Do you have Advanced Directives? ☐ No ☐ Yes Living Will? ☐ No ☐ Yes

If yes, is the documentation on file at a Southwest Medical Group clinic or your Primary Care Provider? ☐ No ☐ Yes

Risk Factors

Do you or have you used tobacco products? ☐ Yes, current ☐ Yes, former ☐ Never

If yes, what type? (cigarettes, chew, pipe, etc.)_____

If a cigarette smoker: _____ pack(s) Age started? _____ If former, year you quit?_____

If current smoker, would you like help in quitting? ☐ No ☐ Yes

Is there tobacco use by others in the home? ☐ No ☐ Yes

If yes, what type? (cigarettes, chew, pipe, etc.)_____

Do you use recreational drugs? ☐ No ☐ Yes ☐ Rarely If yes, what kind?_____

Do you drink alcohol? ☐ No ☐ Yes ☐ Rarely If yes, what kind?_____

If yes, _____ drinks/day, _____ drinks/week, _____ drinks/month

Do you drink caffeinated beverages? ☐ No ☐ Yes ☐ Rarely

If yes, what kind?_____ If yes, _____drinks/day

Do you exercise regularly? ☐ No ☐ Yes If yes, what activities? _____ Days/Week_____

Do you wear a seat belt? ☐ No ☐ Yes If you have children, do they wear a seat belt? ☐ No ☐ Yes